

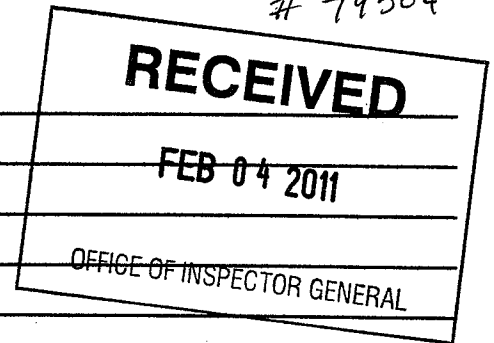
Application for License to  
Operate a Long-term Care Facility

For Office Use Only  
Received: 2/4/11  
Amount: 155.00

# 79504

I. IDENTIFICATION

Name King's Daughters Medical Center  
Address 2201 Lexington Avenue  
City/County/Zip Ashland, Boyd, 41101  
Telephone number 606-327-4000  
Administrator Danny Joe Brainard, Jr.  
Date facility operation began at current address 1985  
Date facility began operation under current owner 1985



II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled	<u>0</u>	<u>0</u>
Nursing Home	<u>0</u>	<u>0</u>
Nursing Facility	<u>10</u>	<u>10</u>
Intermediate Care	<u>0</u>	<u>0</u>
ICF/MR	<u>0</u>	<u>0</u>
Personal Care	<u>0</u>	<u>0</u>

II. CONTROL (Check one in each column)

State \_\_\_\_\_  
County \_\_\_\_\_  
City \_\_\_\_\_  
Private

Profit \_\_\_\_\_  
Non Profit

Individual Partnership \_\_\_\_\_  
Corporation

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ACCOUNTING

II. OWNERSHIP

Name and address of individual owner, partner or corporation. If partnership, list partners.

Ashland Hospital Corporation

(OVER)

2/23

If facility is owned by a corporation, complete the following:

Name of corporation	<u>Ashland Hospital Corporation</u>
Address of corporation	<u>2201 Lexington Avenue Ashland Kentucky 41101</u>
President or Chairman	<u>David Jones</u>
Vice President	<u>Ray Mecca, MD</u>
Secretary	<u>Sheryl Mahaney</u>
Treasurer	<u>Paul McDowell</u>

Attach a separate sheet listing the names and addresses of each person having at least twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. (see attached list)

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
<u>Ashland Hospital Corporation</u>	<u></u>
<u>2201 Lexington Avenue</u>	<u></u>
<u>Ashland, Kentucky 41101</u>	<u></u>

I understand that any change in the application that affects my licensure status will be reported to the Division of Community Health Services and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Danny Joe Brainerd Jr.  
Signature of Authorized Representative

Administrator  
Title

1/27/11  
Date

Return Application and Fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)